471-000-524 Nebraska Medicaid Practitioner Fee Schedule for Visual Care Services

Nebraska Medicaid payment is the lower of the fee schedule allowable or the provider's submitted charge(s). The provider's submitted charge(s) must reflect their charge to the general public. CPT codes, descriptions and other data only are the copyright 2014 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DRARS apply. Relative Values for Physicians copyright 2014 Ingenix, Inc.

HCPCS procedure codes are defined by the Centers for Medicare and Medicaid Services (CMS). For HCPCS procedure code definitions, refer to the CMS website at http://www.cms.hhs.gov HCPCS procedure code manuals are available through private vendors.

*"IC" (Invoice Cost) – Paid at invoice cost. An invoice must be submitted with the claim. Some of these services may also have an associated maximum allowable and will be reimbursed at the lower of invoice cost or maximum allowable.

*"BR" (By Report) – Paid at "reasonable charge" based on the service and circumstances. A complete description of the service (and additional documentation, if applicable) is required for review.

'22' Modifier is no longer used with vision codes below.

						MEDICAID
CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
000V2020		FRAMES		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$43.15
000V2100		SPHERE, SINGLE VISION, PLANO TO 4.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$12.68
000V2101		SPHERE, SINGLE VISION, 4.12 TO 7.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$14.70
000V2102		SPHERE, SINGLE VISION, 7.12 TO 20.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$27.95
000V2103		SPHEROCYLINDER, SINGLE VISION, PLANO TO 4.00D, .12 TO 2.00, PER LENSº		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$14.32
000V2104		SPHEROCYLINDER, SINGLE VISION, PLANO TO 4.00D, 2.12 TO 4.00		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$15.58
000V2105		SPHEROCYLINDER, SINGLE VISION, PLANO TO 4.00D, 4.25 TO 6.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$17.12
000V2106		SPHEROCYLINDER, SINGLE VISION, PLANO TO 4.00D, OVER 6.00 CYL, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$19.72
000V2107		SPHEROCYLINDER, SINGLE VISION, 4.25 TO 7.00, .112 TO 2.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$16.55

						MEDICAID
CODE	MOD	DESCRIPTION	PA	COMMENTS	COPAY	ALLOWABLE
000V2108		SPHEROCYLINDER, SINGLE VISION, 4.25D TO 7.00, 2.12 TO 4.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$17.80
000V2109		SPHEROCYLINDER, SINGLE VISION, 4.25 TO 7.00D, 4.25 TO 6.00 CYL, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$19.42
000V2110		SPHEROCYLINDER, SINGLE VISION, 4.25 TO 7.00D, OVER 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$22.00
000V2111		SPHEROCYLINDER, SINGLE VISION, 7.25 TO 12.00, .25 TO 2.25, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$19.64
000V2112		SPHEROCYLINDER, SINGLE VISION, 7.25 TO 12.00, 2.25 TO 4.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$20.76
000V2113		SPHEROCYLINDER, SINGLE VISION, 7.25 TO 2.00D, 4.25 TO 6.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$21.59
000V2114		SPHEROCYLINDER, SINGLE VISION, SPHERE OVER PLUS OR MINUS 12.00D PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$33.46
000V2115		LENTICULAR, (MYODISC), PER LENS, SINGLE VISION ("ADD ON" BEFORE 9/1/96)		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$25.89
000V2118		ANISEIKONIC LENS, SINGLE VISION		IC	X	
000V2121		LENTICULAR LENS, PER LENS, SINGLE		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$43.12
000V2199		NOT OTHERWISE CLASSIFIED, SINGLE VISION LENS (MED SVS REVIEW)		IC	X	
000V2200		SPHERE, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$24.28
000V2201		SPHERE, BIFOCAL, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$27.02
000V2202		SPHERE, BIFOCAL, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$40.70
000V2203		SPHEROCYLINDER, BIFOCAL, PLANO TO 4.00D, .12 TO 2.00D, PER LENS		IC	X	$26.08

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
000V2204		SPHEROCYLINDER, BIFOCAL, PLANO TO PLUS OR MINUS 4.00D SPHERE, 2.12 TO 4.		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$27.40
000V2205		SPHEROCYLINDER, BIFOCAL, PLANO TO 4.00D SPHERE, 4.25 TO 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$29.27
000V2206		SPHEROCYLINDER, BIFOCAL, PLANO TO 4.00, OVER 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$31.99
000V2207		SPHEROCYLINDER, BIFOCAL, 4.25 TO 7.00D, .12 TO 2.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$29.33
000V2208		SPHEROCYLINDER, BIFOCAL, 4.25 TO 7.00D, 2.12 TO 4.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$30.47
000V2209		SPHEROCYLINDER, BIFOCAL, 4.25 TO 7.00D, 4.25 TO 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$32.55
000V2210		SPHEROCYLINDER, BIFOCAL, 4.25 TO 7.00D. OVER 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$35.38
000V2211		SPHEROCYLINDER, BIFOCAL, 7.25 TO 12.00D, .25 TO 2.25D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$32.37
000V2212		SPHEROCYLINDER, BIFOCAL, 7.25 TO 12.00D, 2.25 TO 4.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$33.71
000V2213		SPHEROCYLINDER, BIFOCAL, 7.25 TO 12.00D, 4.25 TO 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$35.58
000V2214		SPHEROCYLINDER, BIFOCAL, SPHERE OVER PLUS OR MINUS 12.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$44.24
000V2215		LENTICULAR (MYODISC), PER LENS, BIFOCAL ("ADD-0N" BEFORE 9/1/96) (INVOICE REQUIRED)		IC	X	
000V2218		ANISEIKONIC, PER LENS, BIFOCAL		IC	X	
000V2219		BIFOCAL SEG WIDTH OVER 28MM		IC NOT TO EXCEED MEDICAID ALLOWABLE		$4.31
000V2220		BIFOCAL ADD OVER 3.25D		IC NOT TO EXCEED MEDICAID ALLOWABLE		$7.19
000V2221		LENTICULAR LENS, PER LENS, BIFOCAL		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$46.03
000V2299		SPECIALTY BIFOCAL (BY REPORT) (MED SVS REVIEW)		IC	X	

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
000V2300		SPHERE, TRIFOCAL, PLANO TO PLUS OR MINUS 4.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$32.61
000V2301		SPHERE, TRIFOCAL, PLUS OR MINUS 4.12 TO PLUS OR MINUS 7.00D PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$35.03
000V2302		SPHERE, TRIFOCAL, PLUS OR MINUS 7.12 TO PLUS OR MINUS 20.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$48.55
000V2303		SPHEROCYLINDER, TRIFOCAL, PLANO TO 7.00D SPHERE, .12-2.00D CYL, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$34.26
000V2304		SPHEROCYLINDER, TRIFOCAL, PLANO TO 4.00D, 2.25-4.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$35.58
000V2305		SPHEROCYLINDER, TRIFOCAL, PLANO TO 4.00D, 4.25 TO 6.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$37.46
000V2306		SPHEROCYLINDER, TRIFOCAL, PLANO TO 4.00D, OVER 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$40.18
000V2307		SPHEROCYLINDER, TRIFOCAL, 4.25 TO 7.00D, .12 TO 2.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$36.87
000V2308		SPHEROCYLINDER, TRIFOCAL, 4.25 TO 7.00D, 2.12 TO 4.00D,PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$38.18
000V2309		SPHEROCYLINDER, TRIFOCAL, 4.25 TO 7.00D, 4.25 TO 6.00,PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$40.13
000V2310		SPHEROCYLINDER, TRIFOCAL, 4.25 TO 7.00D, OVER 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$42.79
000V2311		SPHEROCYLINDER, TRIFOCAL, 7.25 TO 12.00D, .25 TO 2.25, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$40.19
000V2312		SPHEROCYLINDER, TRIFOCAL, 7.25 TO 12.00D, 2.25 TO 4.00, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$41.33
000V2313		SPHEROCYLINDER, TRIFOCAL, 7.25 TO 12.00D, 4.25 TO 6.00D, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$43.19
000V2314		SPHEROCYLINDER, TRIFOCAL, SPHERE OVER 12.00, ANY CYLINDER, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$54.30

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
000V2315		LENTICULAR, (MYODISC), PER LENS, TRIFOCAL (ADD ON CHARGE BEFORE 9/1/96)		IC	X	
000V2318		ANISEIKONIC LENS, TRIFOCAL/		IC	X	
000V2319		TRIFOCAL SEG WIDTH OVER 28 MM (ADD ON CHARGE)		IC NOT TO EXCEED MEDICAID ALLOWABLE		$8.62
000V2320		TRIFOCAL ADD OVER 3.25D (ADD ON CHARGE)		IC NOT TO EXCEED MEDICAID ALLOWABLE		$7.19
000V2321		LENTICULAR LENS, PER LENS, TRIFOCAL		IC NOT TO EXCEED MEDICAID ALLOWABLE	X	$61.85
000V2399		SPECIALTY TRIFOCAL (BY REPORT) (MED SVS REVIEW)		IC	X	
000V2410		VARIABLE SPHERICITY LENS, SINGLE VISION, FULL FIELD, GLASS OR PLASTIC, PPER LENS		IC	X	
000V2430		VARIABLE SPHERICITY LENS, BIFOCAL, FULL FIELD, GLASS OR PLASTIC PER LENS		IC	X	
000V2499		NOT OTHERWISE CLASSIFIED, VARIABLE SPHERICITY LENS		IC	X	
000V2500		CONTACT LENS, PMMA, SPHERICAL, PER LENS (HARD CONTACT LENSES)		IC		
000V2501		CONTACT LENS, PMMA, TORIC OR PRISM BALLAST, PER LENS(HARD CONTACT LENSES)		IC		
000V2502		CONTACT LENS PMMA, BIFOCAL, PER LENS (HARD CONTACT LENSES)		IC		
000V2503		CONTACT LENS PMMA, COLOR VISION DEFICIENCY, PER LENS(HARD CONTACT LENSES)		IC		
000V2510		CONTACT LENS, GAS PERMEABLE, SPHERICAL, PER LENS		IC		
000V2511		CONTACT LENS, GAS PERMEABLE, TORIC, PRISM BALLAST, PER LENS		IC		
000V2512		CONTACT LENS, GAS PERMEABLE, BIFOCAL, PER LENS		IC		
000V2513		CONTACT LENS, GAS PERMEABLE, EXTENDED WEAR, PER LENS		IC		
000V2520		CONTACT LENS HYDROPHILIC, SPERICAL PER LENS		IC		

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
000V2521		CONTACT LENS HYDROPHILIC TORIC OR PRISM BALLAST PER LENS		IC		
000V2522		CONTACT LENS HYDROPHILIC BIFOCAL PER LENS		IC		
000V2523		CONTACT LENS HYDROPHILIC EXTENDED WEAR, PER LENS		IC		
000V2530		CONTACT LENS SCLERAL, GAS IMPERMEABLE, PER LENS		IC		
000V2531		CONTACT LENS, SCLERAL, GAS PERMEABLE, PER LENS		NOT COVERED		
000V2599		CONTACT LENS, OTHER TYPE		IC		
000V2623		PROSTHETIC EYE, PLASTIC CUSTOM FI CHANGED TO 'S' 6/95				$1,145.74
000V2624		POLISHING/RESURFACING OF OCULAR PROSTHESIS				$59.02
000V2625		ENLARGEMENT OF OCULAR PROSTHESIS				$478.49
000V2626		REDUCTION OF OCULAR PROSTHESIS				$258.13
000V2627		SCLERAL COVER SHELL (CORRECTED UV FROM 7.64 TO 76.4 ON 6/27/97)				$1,202.53
000V2628		FABRICATION AND FITTING OF OCULAR CONFORMER				$393.50
000V2629		NOT OTHERWISE CLASSIFIED PROSTHETIC EYE (MED SVS REVIEW)		BR		
000V2700		BALANCE LENS PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE		$50.35
000V2702		DELUXE LENS FEATURE		NOT COVERED		
000V2710		SLAB OFF PRISM, GLASS OR PLASTIC, PER LENS(ADD ON CHARGE) (MED SVS REVIEW)		IC NOT TO EXCEED MEDICAID ALLOWABLE		$57.54
000V2715		PRISM, PER LENS (ADD ON CHARGE)		IC NOT TO EXCEED MEDICAID ALLOWABLE		$28.77
000V2718		PRESS ON LENS FRESNELL PRISM PER LENS(ADD ON CHARGE)		IC NOT TO EXCEED MEDICAID ALLOWABLE		$21.57
000V2730		SPECIAL BASE CURVE, GLASS OR PLASTIC, PER LENS (ADD ON CHARGE) (MED SVS REVIEW)		IC NOT TO EXCEED MEDICAID ALLOWABLE		$14.38

						MEDICAID
CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
000V2744		TINT PHOTOCHROMATIC PER LENS (NOT COVERED)		NOT COVERED		
000V2745		ADDITION TO LENS; TINT, ANY COLOR, SOLID, GRADIENT OR EQUAL, EXCLUDES PHOTOCHROMATIC, ANY LENS MATERIAL, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE		$7.19
000V2750		ANTI REFLECTIVE COATING PER LENSNOT COVERED.		NOT COVERED		
000V2755		UV LENS, PER LENS(ADD ON CHARGE)		IC NOT TO EXCEED MEDICAID ALLOWABLE		$8.62
000V2756		EYE GLASS CASE		IC NOT TO EXCEED MEDICAID ALLOWABLE		$1.09
000V2760		SCRATCH RESISTANT COATING PER LENS		NOT COVERED		
000V2761		MIRROR COATING, ANY TYPE, SOLID, GRADIENT OR EQUAL, ANY LENS MATERIAL, PER LENS		NOT COVERED		
000V2762		POLARIZATION, ANY LENS MATERIAL, PER LENS		NOT COVERED		
000V2770		OCCLUDER LENS, PER LENS		IC NOT TO EXCEED MEDICAID ALLOWABLE		$9.44
000V2780		OVERSIZE LENS, PER LENS (ADD ON CHARGE)		IC NOT TO EXCEED MEDICAID ALLOWABLE		$5.74
000V2781		PROGRESSIVE LENS, PER LENS (NOT COVERED)		NOT COVERED		
000V2782		LENS, INDEX 1.54 TO 1.65 PLASTIC OR 1.60 TO 1.79 GLASS, EXCLUDES POLYCARBONATE, PER LENS		IC		
000V2783		LENS, INDEX GREATER THAN OR EQUAL TO 1.66 PLASTIC OR GREATER THAN OR EQUAL TO 1.80 GLASS, EXCLUDES POLYCARBONATE, PER LENS		IC		
000V2784		LENS, POLYCARBONATE OR EQUAL, ANY INDEX, PER LENS (ADD-ON CODE TO A LENS CODE)--EFFECTIVE 01/01/2006		IC NOT TO EXCEED MEDICAID ALLOWABLE		$10.91
000V2786		SPECIALTY OCCUPATIONAL MULTIFOCAL LENS, PER LENS		NOT COVERED		
000V2797		VISION SUPPLY, ACCESSORY AND/OR SERVICE COMPONENT		NOT COVERED		

						MEDICAID
CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
		OF ANOTHER HCPCS VISION CODE				
000V2799		VISION ITEM OR SERVICE, MISCELLANEOUS		IC NOT TO EXCEED MEDICAID ALLOWABLE, SEE WORD DOCUMENT		
00065205		REMOVAL OF FOREIGN BODY, EXTERNAL EYE; CONJUNCTIVAL SUPERFICIAL				$38.00
00065210		CONJUNCTIVAL EMBEDDED (INCLUDES CONCRETIONS), SUBCONJUNCTIVAL OR SCLERAL, NONPERFORATING				$43.43
00065220		CORNEAL, WITHOUT SLIT LAMP				$43.43
00065222		CORNEAL, WITH SLIT LAMP				$65.14
00065430		SCRAPING CORNEA, DIAGNOSTIC, FOR SMEAR AND/OR CULTURE REVIEW OVER 50.00				$32.57
00067820		CORRECTION TRICHIASIS, EPILATION, FORCEPS ONLY				$21.71
00067938		REMOVAL EMBEDDED FOREIGN BODY, EYELID				$48.86
00068040		EXPRESSION CONJUNCTIVAL FOLLICLES, EG, FOR TRACHOMA (5777) REVIEW OVER 50.00				$38.00
00068761		CLOSURE OF THE LACRIMAL PUNCTUM; BY PLUG, EACH				$103.15
00068801		DILATION OF LACRIMAL PUNCTUM, W OR WO IRRIGATION				$54.29
00068810		PROBING OF NASOLACRIMAL DUCT, WITH OR WO IRRIGATION				$108.58
00076511		OPHTHALMIC ULTRASOUND, DIAGNOSTIC; QUANTITATIVE A-SCAN ONLY				$112.38
00076511	TC	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; QUANTITATIVE A-SCAN ONLY				$63.94
00076511	26	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; QUANTITATIVE A-SCAN ONLY				$48.44
00076512		OPHTHALMIC ULTRASOUND, DIAGNOSTIC; B-SCAN (WITH OR				$105.70

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
		WITHOUT SUPERIMPOSED NON-QUANTITATIVE A-SCAN)				
00076512	TC	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; B-SCAN (WITH OR WITHOUT SUPERIMPOSED NON-QUANTITATIVE A-SCAN)				$57.08
00076512	26	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; B-SCAN (WITH OR WITHOUT SUPERIMPOSED NON-QUANTITATIVE A-SCAN)				$48.61
00076513		OPHTHALMIC ULTRASOUND, DIAGNOSTIC; ANTERIOR SEGMENT ULTRASOUN, IMMERSION (WATER BATH), B-SCAN OR HIGH RESOLUTION BIOMICROSCOPY				$87.50
00076513	TC	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; ANTERIOR SEGMENT ULTRASOUND, IMMERSION (WATER BATH); B-SCAN OR HIGH RESOLUTION BIOMICROSCOPY				$53.56
00076513	26	OPHTHALMIC ULTRASOUND, DIAGNOSTIC; ANTERIOR SEGMENT ULTRASOUND, IMMERSION (WATER BATH); B-SCAN OR HIGH RESOLUTION BIOMICROSCOPY				$33.93
00076514		OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; CORNEAL PACHYMETRY, UNILATERAL OR BILATERAL (DETERMINATION OF CORNEAL THICKNESS)				$11.66
00076514	TC	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; CORNEAL PACHYMETRY, UNILATERAL OR BILATERAL (DETERMINATION OF CORNEAL THICKNESS)				$2.64
00076514	26	OPHTHALMIC ULTRASOUND, ECHOGRAPHY, DIAGNOSTIC; CORNEAL PACHYMETRY, UNILATERAL OR BILATERAL				$9.02

						MEDICAID
CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
		(DETERMINATION OF CORNEAL THICKNESS)				
00076516		OPTHALMIC BIOMETRY BY ULTRASOUND ECHOGRAPHY; A-MODE				$70.08
00076516	TC	OPTHALMIC BIOMETRY BU ULTRASOUND EXHOGRAPHY; A-MODE; TECHNICAL COMPONENTUNIT VALUE CORRECTED 9/96				$42.11
00076516	26	ECHOGRAPHY, OPTHALMIC BIOMETRY, A-,ODE				$27.97
00076519		******* WITH INTRAOCULAR LENS POWER CALCULATION				$73.60
00076519	TC	********WITH INTRAOCULAR LENS POWER CALCULATION; TECHNICAL COMPONENT PRICING CORRECTED 6-12-95 AND 9-23-96)				$45.63
00076519	26	WITH INTRAOCULAR LENS POWER CALCULATION				$27.97
00076529		OPHTHALMIC ULTRASOUND FOREIGN BODY LOCALIZATION				$68.77
00076529	TC	OPHTHALMIC ULTRASOUND FOREIGN BODY LOCALIZATION; TECHNICAL COMPONENT UNIT VALUE CORRECTED 9/96				$39.82
00076529	26	OPTHALMIC ULTRASOUND FOREIGN BODY LOCALIZATTON				$28.95
00092002		OPHTHALMOLOGICAL SERVICES, MEDICAL EXAMINATION AND EVALUATION WITH INITIATION OF DIAGNOSTIC AND TREATMENT PROG., INTERMEDIATE, NEW PT			X	$37.19
00092004		COMPREHENSIVE, NEW PATIENT, ONE OR MORE SESSIONS MCG UNITS 7/91			X	$58.05
00092012		OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION, WITH INITIATION OR CONTINUATION OF DIAGNOSTIC AND TREATMENT PROGRAM, INTERMEDIATE			X	$37.19

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
00092014		COMPREHENSIVE, ESTABLISHED PATIENT, ONE OR MORE SESSIONS			X	$50.06
00092015		DETERMINATION OF REFRACTIVE STATE (BEFORE 12/1/93 PAY ONLY ON MEDICARE CROSSOVER CLAIM; AFTER 12/1/93 DOS, OK TO PAY)				$16.08
00092020		GONIOSCOPY WITH INTERPRETATION AND REPORT (SEPARATE PROCEDURE)				$40.20
00092025		COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT				$20.10
00092060		SENSORIMOTOR EXAMINATION WITH MULTIPLE MEASUREMENTS OF OCULAR DEVIATION,WITH INTERPRETATION & REPORT (SEPARATE PROCEDURE)				$32.16
00092065		ORTHOPTIC AND/OR PLEOPTIC TRAINING, WITH CONTINUING MEDICAL DIRECTION AND EVALUATION				$24.12
00092071		FITTING OF CONTACT LENS FOR TREATMENT OF OCULAR SURFACE DISEASE				$112.56
00092072		FITTING OF CONTACT LENS FOR MANAGEMENT OF KERATOCONUS, INITIAL FITTING				$112.56
00092081		VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH INTERP. & REPORTLIMITED EXAMINATION (EG, TANGENT SCREEN, AUTOPLOT...				$30.15
00092082		******** INTERMEDIATE EXAMINATION (EG, AT LEAST 2 ISOPTERS ON GOLDMANN PERIMETER, OR SEMIQUANTITATIVE, AUTOMATED SUPRATHRESHOLD SCREENING ...				$38.19

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
00092083		VISUAL FIELD EXAM, EXTENDED, (EG GOLDMANN VISULA FIELD W/AT LEAST 3 ISOPTERS PLOTTED AND STATIC DETERMINATION W/IN THE CENTRAL 30 OR QUANT, AUTO				$50.25
00092100		SERIAL TONOMETRY (SEPARATE PROCEDURE) WITH MULTIPLE MEASUREMENTS OFINTRAOCULAR PRESSURE OVER AN EXTENDED TIME PERIOD WITH INTERP & REPORT..				$16.08
00092132		SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, ANTERIOR SEGMENT, WITHINTERPRETATION AND REPORT, UNILATERAL OR BILATERAL		PER EYE		$28.94
00092133		SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; OPTIC NERVE		PER EYE		$35.37
00092134		SCANNING COMPUTERIZED OPHTHALMIC DIAGNOSTIC IMAGING, POSTERIOR SEGMENT, WITH INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL; RETINA		PER EYE		$35.37
00092136		OPHTHALMIC BIOMETRY BY PARTIAL COHERENCE INTERFEROMETRY WITH INTRAOCULAR LENS POWER CALCULATION		PER EYE		$77.18
00092140		PROVOCATIVE TESTS FOR GLAUCOMA, WITH INTERP & REOPRT, WITHOUT TONOGRAPHY		PER EYE		$21.30
00092225		OPTHALMOSCOPY, EXTENDED WITH RETINAL DRAWING, WITH INTERP & REPORT;INITIAL - UNILATERAL		PER EYE		$32.16

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00092226		OPHTHALMOSCOPY, EXTENDED, WITH RETINAL DRAWING, WITH MEDICAL DIAGNOSTIC EVALUATION, SUBSEQUENT		PER EYE		$28.14
00092230		FLUORESCEIN ANGIOSCOPY WITH INTERP. & REPORT				$80.40
00092235		FLUORESCEIN ANGIOGRAPHY,(INCLUDES MULTI FRAME IMAGING) WITH INTERP & REPORT				$82.41
00092235	26	FLUORESCEIN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERP &REPORT				$48.24
00092240		INDOCYANINE-GREEN ANGIOGRAPHY (INC. MULTIFRAME IMAGING) WITH INTERPRETA-TION AND REPORT				$92.46
00092240	26	INDOCYANINE-GREEN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION AND REPORT				$56.28
00092250		FUNDUS PHOTOGRAPHY WITH INTERP & REPORT				$66.33
00092250	26	FUNDUS PHOTOGRAPHY W/ INTERP & REPORT - PROFESSIONAL COMP.				$52.26
00092260		OPHTHALMODYNAMOMETRY				$44.22
00092265		NEEDLE OCULOELECTROMYOGRAPHY, ONE OR MORE EXTRAOCULAR MUSCLES, ONE OR BOTH EYES, WITH INTERP & REPORT				$70.35
00092265	26	NEEDLE OCULOELECTROMYOGRAPHY, ONE OR MORE EXTRAOCULAR MUSCLES, ONE OR BOTH EYES, WITH INTERP & REPORT				$60.30
00092270		ELECTROOCULOGRAPHY, WITH INTERP & REPORT				$70.35
00092270	26	ELECTROCULOGRAPHY, WITH INTERP & REPORT - PROFESSIONAL COMP.				$60.30

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00092275		ELECTRORETINOGRAPHY, WITH INTERP & REPORT		PER EYE		$70.35
00092275	26	ELECTRORETINOGRAPHY, PROFESSIONAL COMPONENT		PER EYE		$60.30
00092283		COLOR VISION EXAMINATION, EXTENDED, EG, ANOMALOSCOPE OR EQUIVALENT				$40.20
00092283	26	COLOR VISION EXAMINATION, EXTENDED, EG, ANOMALSCOPE OR EQUIVALENT				$28.14
00092284		DARK ADAPTATION EXAMINATION, WITH INTERP & REPORT				$34.17
00092284	26	DARK ADAPTATION EXAMINATION, W/ INTERP AND REPORT				$24.12
00092285		EXTERNAL OCULAR PHOTOGRAPHY WITH INTERP & REPORT FORDOCUMENTATION OF MEDICAL PROGRESS (EG, CLOSE UP PHOTOGRAPHY, SLIT LAMP)		PER EYE		$14.07
00092285	26	EXTERNAL OCULAR PHOTOGRAPHY W/ INTERP & REPORT FOR DOCUMENTATION OFMEDICAL PROGRESS		PER EYE		$10.05
00092286		SPECIAL ANTERIOR SEGMENT PHOTOGRAPHY WITH INTERP. & REPORT; WITH SPECULAR ENDOTHELIAL MICROSCOPY AND CELL COUNT		PER EYE		$60.30
00092286	26	SPECIAL ANTERIOR SEGMENT PHOTOGRAPHY W/ INTERP & REPORT; WITH SPECULAR ENDOTHELIAL MICROSCOPY & CELL COUNT		PER EYE		$52.26
00092287		******** WITH FLOURESCEIN ANGIOGRAPHY		PER EYE		$48.24
00092310		PRESCRIBING OPTICAL AND PHYSICAL CHARACTER & FITTING OF CONTACT LENS PROTHESIS, SUP OF ADAPT, WITH CONT MEDICAL DIAG, BOTH EYES				$96.48

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
00092311		CORNEAL LENS FOR APHAKIA, ONE EYE				$104.52
00092312		CORNEAL, FOR APHAKIA, BOTH EYES				$112.56
00092313		CORNEOSCLERAL				$112.56
00092314		PRESCRIBING OPTICAL AND PHYSICAL CHARACTER. OF CONTACT LENS PROSTHESIS &DIRECT OF FITTING BY INDEP TECHN AND MED SUP(NONCOVERED SERVICE)		NOT COVERED		
00092315		CORNEAL LENS FOR APHAKIA, ONE EYE(NONCOVERED SERVICE)		NOT COVERED		
00092316		CORNEAL, FOR APHAKIA(NONCOVERED SERVICE)		NOT COVERED		
00092317		CORNEOSCLERAL(NONCOVERED SERVICE)		NOT COVERED		
00092325		MODIFICATION OF CONTACT LENS (INDEPENDENT PROCEDURE), WITH MEDICAL SUPERVISION OF ADAPTATION				$28.14
00092326		REPLACEMENT OF CONTACT LENS (DISPENSING FEE) (UNITS ENTERED 1/27/92)				$32.16
00092340		FITTING OF SPECTACLES MONOFOCAL, EXCEPT FOR APHAKIA				$74.39
00092340	52	FITTING OF SPECTIACLES MONOFOCAL, EXCEPT FOR APHAKIA, (LENS OR FRAME ONLY)		WHEN FITTING FRAME OR LENSES ONLY		$59.51
00092341		BIFOCAL, EXCEPT FOR APHAKIA				$74.39
00092341	52	BIFOCAL, EXCEPT FOR APHAKIA (LENSES OR FRAME ONLY)		WHEN FITTING FRAME OR LENSES ONLY		$59.51
00092342		MULTIFOCAL, OTHER THAN BIFOCAL, EXCEPT FOR APHAKIA				$87.26
00092342	52	MULTIFOCAL, OTHER THAN BIFOCAL, EXCEPT FOR APHAKIA (LENSES OR FRAME ONLY) (FACTOR INDICATOR CORRECTED FROM A TO 1- 1/14/92)		WHEN FITTING FRAME OR LENSES ONLY		$69.80
00092352		MONOFOCAL, FOR APHAKIA				$74.39

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00092352	52	MONOFOCAL, FOR APHAKIA (LENSES OR FRAME ONLY)		WHEN FITTING FRAME OR LENSES ONLY		$59.51
00092353		MULTIFOCAL, FOR APHAKIA				$87.26
00092353	52	MULTIFOCAL, FOR APHAKIA (LENSES OR FRAME ONLY)		WHEN FITTING FRAME OR LENSES ONLY		$69.81
00092354		LOW VISION AID, SINGLE ELEMENT SYSTEM(NONCOVERED ITEM)		NOT COVERED		
00092355		LOW VISION AID, TELESCOPIC OR OTHER COMPOUND LENS SYSTEM(NONCOVERED ITEM)		NOT COVERED		
00092358		PROSTHESIS SERVICE FOR APHAKIA, TEMPORARY DISPOSABLE OR LOAN (INCLUDING MATERIALS)		NOT COVERED		
00092370		REPAIR AND REFITTING SPECTACLES, EXCEPT FOR APHAKIA				$30.04
00092371		SPECTACLE PROSTHESIS FOR APHAKIA		NOT COVERED		
00092499		UNLISTED OPHTHALMOLOGICAL SERVICE OR PROCEDURE		REQUIRES DOCUMENTATION		
00092531		SPONTANEOUS NYSTAGMUS,INCLUDING GAZE (INTERNAL PRICING PRIOR TO 1-1-91 ENTERED 2-2-91)		NOT COVERED		
00092532		POSITIONAL NYSTAGMUS TEST		NOT COVERED		
00092533		CALORIC VESTIBULAR TEST, EACH IRRIGATION (BINAURAL, BITHERMAL STIMULATION CONSTITUTES FOUR TESTS)		NOT COVERED		
00092534		OPTOKINETIC NYSTAGMUS TEST		NOT COVERED		
00099070		SUPPLIES AND MATERIALS PROVIDED BY THE PHYSICIAN OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT..		REQUIRES DOCUMENTATION		
00099201		OFFICE OR OTHER OUTPATIENT VISIT FOR E/M OF A NEW PATIENT,WHICH REQUIRESTHESE THREE KEY COMPONENTS: PROBLEM FOCUSED HIST.& EXAM., STRAIGHT- ETC			X	$32.30

						MEDICAID
CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
00099202		OFFICE OR OTHER OUTPATIENT VISIT FOR E/M OF NEW PATIENT, REQUIRES THESE 3 KEY COMPONENTS:EXPANDED PROBLEM FOCUSED HIST.& EXAM,STRAIGHTFORWARDETC			X	$47.21
00099203		OFFICE OR OTHER OUTPATIENT VISIT FOR E/M OF NEW PATIENT, REQUIRES 3 KEY COMPONENTS: DETAILED HIST.& EXAM;& MED. DEC.MAKING OF LOW COMPLEXITY			X	$69.58
00099204		OFFICE OR OTHER OUTPATIENT VISIT FOR E/M OF NEW PATIENT, REQUIRES 3 KEY COMPONMENTS;COMPREHENSIVE HIST.& EXAM, & MED. DEC.MAKING OF MODERATE COM			X	$104.21
00099205		OFFICE OR OTHER OUTPATIENT VISIT FOR E/M OF NEW PATIENT, REQUIRES 3 KEY COMPONENTS;COMPREHENSIVE HIST.& EXAM& MED.DEC-MAKING OF HIGH COMPLEXITY			X	$131.18
00099211		OFFICE OR OTHER OUTPAT. VISIT FOR E/M OF ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN.			X	$17.39
00099212		OFFICE OR OTHER OUTPATIENT VISIT FOR E/M OF ESTABLISHED PATIENT,REQUIRESAT LEAST 2 OF 3 KEY COMP.;PROBLEM FOCUSED HIST.& EXAM;STRAIGHTFRWD M.D-M			X	$29.82
00099213		OFFICE OR OTHER OUTPAT.VISIT FOR E/M OF ESTAB.PATIENT;REQUIRES AT LEAST 2 OF 3 COMPONENTS;EXPANDED PROBLEM FOCUSED HIST. & EXAM;MED.DEC. LOW COM			X	$45.07

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
00099214		OFFICE OR OTHER OUTPAT.VISIT FOR E/M OF ESTAB.PATIENT,REQUIRES AT LEAST 2 OF 3 KEY COMPONENTS;DETAILED HIST.& EXAM;MED.DEC-MAKING OF MODERATE			X	$67.78
00099215		OFFICE OR OTHER OUTPAT.VISIT FOR E/M OF ESTABLISHED PATIENT, REQUIRES AT LEAST 2 OF 3 KEY COMPONENTS;COMPREHENSIVE HIST.& EXAM;MED.DEC-MAK HIGH			X	$96.91
00099217		OBSERVATION CARE DISCHARGE DAY MANAGEMENT; CANNOT BE BILLED ON SAMEDATE AS INITIAL OBSERVATION CARE				$36.18
00099218		INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A				$48.24
00099219		INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE				$86.43
00099220		INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE				$108.54
00099221		INITIAL HOSPITAL CARE, PER DAY, FOR THE E/M OF PATIENT WHICH REQUIRES 3 KEY COMPONENTS;COMP. HIST.& EXAM,&MED.DEC-MAKING STRAIGHTFORWARD OR LOW				$50.25
00099222		INITIAL HOSP.CARE, PER DAY, FOR E/M OF PATIENT;REQUIRES 3 KEY COMPONENTSCOMPREHENSIVE HIST.& EXAM & MED. DEC-				$88.44

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CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
		MAKING OF MODERATE COMPLEXITY				
00099223		INITIAL HOSPITAL CARE, PER DAY, FOR E/M OF PATIENT, REQUIRES 3 KEY COM-				$114.57
00099231		SUBSEQUENT HOSPITAL CARE;PER DAY;PROBLEM FOCUSED; LOW COMPLEXITY; 15 MINS. AT BEDSIDE /UNIT				$30.15
00099232		SUBSEQNT HOSP. CARE;PER DAY; EXPANDED FOCUS;MODERATE COMPLEXITY;				$48.24
00099233		SUBSEQNT. HOSPITAL CARE;PER DAY; DETAILED HISTORY AND EXAM; HIGH COMPLEXITY				$80.40
00099234		OBSV OR IP HOSP CARE, E&M OF PAT INCLUDING ADM & DISCH ON SAME DAY PROB USUALLY OF LOW SEVERITY				$92.46
00099235		OBSV OR IP HOSP CARE, FOR E&M OF PAT INCLUDING ADM & DISCH ON SAME DATE PROBLEMS USUALLY OF MODERATE SEVERITY				$130.65
00099236		OBSV OR IP HOSP CARE FOR E&M OF PATIENT, ADM & DISCH ON SAME DAY. PROBLEM USUALLY OF HIGH SEVERITY				$156.78
00099241		OFFICE CONSULTATION FOR NEW OR ESTABLISHED PATIENTS,REQUIRES 3 KEY COMP-ONENTS;PROBLEM FOCUSED HIST.& EXAM;& STRAIGHTFRWRD MED.DEC.MAKING			X	$48.24
00099242		OFFICE CONSULTATION FOR NEW OR ESTAB. PATIENT, REQUIRES 3 KEY COMPONENTSEXPANDED PROBLEM FOCUSES HIST.& EXAM.& STRAIGHTFORWARD MED. DEC-MAKING			X	$68.34
00099243		OFFICE CONSULTATION FOR NEW OR ESTAB. PATIENT, REQUIRES 3 KEY COMPONENTSDETAILED			X	$88.44

						MEDICAID
CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
		HIST.& EXAM. & MED. DECISION-MAKING OF LOW COMPLEXITY				
00099244		OFFICE CONSULTATION FOR NEW OR ESTAB. PATIENT, REQUIRES 3 KEY COMPONENTSCOMPREHENSIVE HIST.& EXAM.;MED.DEC-MAKING OF MODERATE COMPLEXITY			X	$112.56
00099245		OFFICE CONSULTATION OF NEW OR ESTAB. PATIENT, REQUIRES 3 KEY COMPONENTS,			X	$152.76
00099251		INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE				$52.26
00099252		INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EX				$72.36
00099253		INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION				$92.46
00099254		INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE E				$120.60
00099255		INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE E				$160.80
00099281		EMERGENCY DEPT. VISIT; EVAL/MGMT; PROBLEM FOCUSED; STFRWD. DECISION MKG.				$21.30

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00099282		EMERG. DEPT. VISIT;EVAL. MGMT./ EXPANDED PROBLEM FOCUS;LOW COMPLEXITY				$36.18
00099283		EMERG. DEPT. VISIT; EVAL./MGMT.; EXPAND.PROB.; LOW-MOD. COMPLEXITY (INTERIM VALUE 1/1/92)				$54.27
00099284		EMERG. DEPT. VISIT;EVAL/MGMT; DETAILED HISTORY/EXAM; MODERATE COMPLEXITY(INTERIM VALUE 1/1/92)				$64.32
00099285		EMERG. DEPT. VISIT;EVAL/MGMT.; COMP. HISTORY/EXAM; HIGH COMPLEXITY				$104.52
00099288		PHYSICIAN DIRECTION OF EMERGENCY ADVANCED LIFE SUPPORT PARAMEDIC SERVICES		NOT COVERED		
00099341		HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQ 3 COMPONENTS				$49.70
00099342		HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH INCL ESPANDED HX AND PROBLEM FOCUSED EXAM, LOW COMPLEXITY MED DECISION				$62.12
00099343		HOME VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH INCL DETAILED HX, EXAM & MOD COMPLEXITY DECISION				$93.59
00099344		HOME VISIT FOR E&M OF NEW PAT, PRESENTING PROBLEM USUALLY OF HIGH SEVERITY				$109.34
00099345		HOME VISIT FOR E&M OF NEW PATIENT, USUALLY PATIENT UNSTABLE OR HAS DEVELNEW				$144.13

						MEDICAID
CODE	**MOD**	**DESCRIPTION**	**PA**	**COMMENTS**	**COPAY**	**ALLOWABLE**
		PROB REQUIRING IMMED PHYSICIAN ATTENTION				
00099347		HOME VISIT FOR E&M OF ESTABLISHED PATIENT, PRESENTING PROB USUALLY MINOR OR SELF-LIMITED				$39.76
00099348		HOME VISIT FOR E&M OF ESTABLISHED PT, PRESENTING PROBLEM USUALLY OF LOW TO MOD SEVERITY				$58.28
00099349		HOME VISIT FOR E&M OF ESTABLISHED PT, PRESENTING PROBLEM USUALLY OF MOD TO HIGH SEVERITY				$85.23
00099350		HOME VISIT FOR E&M OF ESTABLISHED PATIENT, PRESENTING PROB USUALLY MOD- HIGH SEVERITY, PT MAY BE UNSTABLE OR DEVELOP NEW PROB REQ IMMED ATTENTIO				$124.25
00099374		PHYSICIAN SUPERVISION OF A PATIENT UNDER CARE OF HOME HEALTH AGENCY (PATIENT AND/OR ADJUSTMENT OF MEDICAL THERAPY, WITHIN A CALENDAR MONTH; 1		NOT COVERED		
00099377		PHYSICIAN SUPERVISION OF A HOSPICE PATIENT (PATIENT NOT PRESENT) REQUIRING THERAPY, WITHIN A CALENDAR MONTH; 15-29 MINUTES		NOT COVERED		
00099379		PHYSICIAN SUPERVISION OF A NURSING FACILITY PATIENT (PATIENT NOT PRESENT) AND/OR ADJUSTMENT OF MEDICAL THERAPY, WITHIN A CALENDAR MONTH; 1		NOT COVERED		
00099499		UNLISTED EVALUATION AND MANAGMENT SERVICE		REQUIRES DOCUMENTATION		